

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/13/2014
NAME OF PROVIDER OR SUPPLIER CASTLETON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7630 E 86TH ST INDIANAPOLIS, IN 46256		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the PSR (Post Survey Revisit) to the Investigation of complaints #IN000141689 and #IN000141749 completed on 1/3/2104</p> <p>This visit was in conjunction with a PSR (Post Survey Revisit) to the investigation of Complaint IN00143626 Survey completed 2/5/2104</p> <p>Complaint IN000141689- Corrected</p> <p>Complaint IN000141749- Corrected</p> <p>Survey dates: March 12 and 13, 2014</p> <p>Facility number: 000149 Provider number: 155245 AIM number: 100266840</p> <p>Survey Team: Jason Mench, RN,TC Angela Selleck, RN Kim Davis, RN</p> <p>Census bed type: SNF: 6 SNF/NF: 46 Total: 52</p> <p>Census payor type: Medicare: 13 Medicaid: 35 Other: 4 Total: 52</p> <p>Castleton Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 Investigation of Complaints #IN000141689 and #IN000141749. Quality review completed by Debora Barth, RN.	{F 000}			